Date: March 8, 2012

From: Genesee County Compassion Club
G 3094 N. Center Road
Flint, MI 48506

To: Michigan House of Representative Judiciary Committee
124 North Capitol Ave., Room 521
Lansing, MI 480909

Re: Rebuttal to the Medical Marihuana Act Amendments

Medical Marihuana Act Amendments
Proposed Substitutes for House Bills 4834, 4851, 4853, and 4856

House Bill 4834

Bill 4834 seeks to ensure validity by requiring a patient registry identification card to contain a photo ID. We understand the need for verification and authenticity; however, we do not feel a photo is necessary to do so. Law enforcement currently has the ability to certify the identity of a registry cardholder by using the State ID in conjunction with a valid registry card.

With regard to extending a valid registry card from one to two years, this seems to be an appropriate inclusion, as most of our participants in the program have long-term disabling conditions. We are not opposed to the privatization of the program, provided the participants' information will be kept confidential and that there are strict penalties for violations. In addition, we would request that the company the State subcontract to be a Michigan owned company.

Considering the above revisions of each of the card programs, we would also like to suggest consideration to revising the current application and renewal fees. The application fees are Twenty-Five Dollars for those individuals who are receiving Disability income, while individuals on Social Security benefits do not receive the discount.

As evidenced (see exhibit A), in the State's report the first two years of the program generated over 8 million in profits, and (particularly in regards to renewals) the One Hundred Dollar fee is somewhat excessive, considering what the actual costs are for re-registering patients and caregivers.

House Bill 4853

As to House Bill 4853, relevant to the code of Criminal Procedure. The current Medical Marihuana law already has additional penalties on top existing drug laws for those who are participating in the program and are caught abusing it. We do not feel adding additional penalties are necessary.

House Bill 4856

To clarify the ability of a patient or caregiver to transport their medications, whether it be inaccessible to the driver or passengers, seems to be a reasonable requirement.

However, the problem is with how it is defined. The words "usable marihuana" as indicated in the bill involving transport has not actually been defined. We have a definition of medical "use", and a definition of "marihuana", but not "Medical Marihuana". This needs to be clearly defined in order to help in this law, and for law enforcement to have a better picture of what is considered "usable marihuana," which also is not clearly defined. An example would be where a patient runs a red light, and has a prescription in their pocket and causes an accident. As long as a doctor issued the patient's prescription, and the patient was not under the influence of the drug, then this would have no bearing on that person or the situation. We feel the same terms applied to the general population should be applied to Medical Marihuana patients. If a patient perhaps forgets and leaves a pipe in his pocket, and goes to the grocery store and is pulled over, they would have to face a misdemeanor because they had access to their medication. If however the patient was "impaired," normal laws should apply.

House Bill 4851

This bill would define the term "bona fide physician-patient relationship". With regard to the "bona fide physician-patient relationship", we feel this relationship has already been defined by the, "Statement of the Board of Medicine and Board of Osteopathic Medicine and Surgery Regarding Certification for Medical Use of Marihuana by Michigan Physicians" (see exhibit B), and requires no further clarification as these requirements and the proposed changes are inherently close.

We applaud the addition of the affirmative defense section being a question to be determined by a jury. This is absolutely necessary, and unbelievable that it was not automatically implanted.

This bill also attempts to clarify what an enclosed locked facility is. We do not feel that by adding the words "comparable" and "completely" to enclosed locked facility do justice to elucidate the issue, also the adding of the word "functioning" to the term "area with locks" does not offer or affect additional clarification. Currently a Supreme Court case (State of Michigan v. King), will likely effect the definition of what is an enclosed locked facility. We feel it would be appropriate to wait for the outcome of this case prior to determining the definition any further.

Enclosures:
State's report Exhibit A
Board of Medicine Exhibit B
Cost of Outsourcing Report Exhibit C
Attorney General Mike Cox's Response Exhibit D
Contract with IdentiSys Inc. and State of Michigan Exhibit E
History of the Genesee County Compassion Club Exhibit F
Standard Paperwork Procedures Exhibit G

Report on the Amount Collected and Cost of Administering the Medical Marihuana Program

(FY2011 Appropriation Bill - Public Act 187 of 2010)

April 1, 2011

Section 726: (1) The department shall submit a report by April 1 of the current fiscal year to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director, on an annual basis, that includes all data on the amount collected from medical marihuana program application and renewal fees along with the cost of administering the medical marihuana program under the Michigan medical marihuana act, 2008 IL 1, MCL 333.26421 to 333.26430. (2) If the required fees are shown to be insufficient to offset all expenses of implementing and administering the medical marihuana program, the department shall review and revise the application and renewal fees accordingly to ensure that all expenses of implementing and administering the medical marihuana program are offset as is permitted under section 5 of the Michigan medical marihuana act, 2008 IL 1, MCL 333.26425.

Michigan Department of Community Health

MDCH

Rick Snyder, Governor
Olga Dazzo, Director

Medical Marihuana Program

	FY 2009	FY 2010	FY 2011
			10-1-2010 thru 3/31/2011
Total Revenue:	$438,921	$4,418,651	$4,860,783
Total Expenditures & Encumbrances	$130,478	$740,658	$687,634
Balance	$308,443	$3,677,993	$4,173,149

Statement of the Board of Medicine and Board of Osteopathic Medicine and Surgery Regarding Certification for Medical Use of Marihuana by Michigan Physicians

The Bureau of Health Professions (BHP) located in the Department of Licensing and Regulatory Affairs is charged with protecting the health, safety and welfare of the people of Michigan. The BHP administers boards for each licensed health profession in Michigan. The boards are charged by statute with establishing standards for education and training, issuing licenses and identifying the standard of care that is expected of those regulated by the law.

In November 2008 the majority of the voters in Michigan approved the Michigan Medical Marihuana Act (MMA) by ballot initiative to protect persons with specific medical conditions from penalties under state law so that they may use marihuana for medical purposes without fear of prosecution. Marihuana remains a Schedule I controlled substance under federal law. The Department and the Boards of Medicine and Osteopathic Medicine and Surgery in Michigan have taken no position on the suitability of marihuana in the treatment of medical disorders.

The MMA is intended to apply to patients with complex, chronic, serious and debilitating medical conditions. It is expected that such patients would require careful and complete evaluation and regular follow-up. The Boards believe that they have an obligation to ensure that members of the public receive proper medical evaluation and advice meeting generally accepted standards of care when seeking certification for use of marihuana for medical purposes.

Both the Department and the Boards are troubled by reports and advertisements of physicians scheduling patient evaluations in clinically inappropriate or inadequate settings and/or within timeframes that do not enable a full and adequate medical assessment to be done. In some instances physicians have conducted certifying evaluations solely through Internet interactions, which are clearly inadequate and inappropriate for the examination of patients for certification for marihuana use. The Boards are concerned that in such instances the public may not be receiving an adequate level of evaluation and treatment as specified by the Public Health Code.

The MMA states:

> *A physician shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by the Michigan board of medicine, the Michigan board of osteopathic medicine and surgery, or any other business or occupational or professional licensing board or bureau, solely for providing written certifications, in the course of a bona fide physician-patient relationship and after the physician has completed a full assessment of the qualifying patient's medical history, or for otherwise*

stating that, in the physician's professional opinion, a patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's serious or debilitating medical condition or symptoms associated with the serious or debilitating medical condition, provided that nothing shall prevent a professional licensing board from sanctioning a physician for failing to properly evaluate a patient's medical condition or otherwise violating the standard of care for evaluating medical conditions. MCL 333.26424 (4)(f)

The standard of care that applies when certifying individuals as candidates for use of medical marihuana is the same as that expected in any other situation in which an individual is being evaluated for medical services. A special standard, higher or lower, is not called for in certifying patients for use of marihuana.

Experts in the field agree with this opinion. Among the advisory recommendations issued by the American Society of Addiction Medicine in September 2010 are the following statements:

> Physicians... in the gatekeeping role have an obligation to help licensing authorities assure that physicians who choose to discuss the medical use of cannabis and cannabis-based products with patients:
>
> > Adhere to the established professional tenets of proper patient care including:
> >
> > - History and good faith examination of the patient
> > - Development of a treatment plan with objectives
> > - Provision of informed consent, including discussion of risks, side effects and potential benefits
> > - Periodic review of the treatment's efficacy
> > - Consultation, as necessary; and
> > - Proper record keeping that supports the decision to recommend the use of cannabis
> >
> > Have a bona fide physician-patient relationship with the patient, i.e., should have a pre-existing and ongoing relationship with the patient as a treating physician;
> >
> > Ensure that the issuance of 'recommendations' is not a disproportionately large (or even exclusive) aspect of their practice;
> >
> > Have adequate training in identifying substance abuse and addiction.

The Board of Medicine and the Board of Osteopathic Medicine and Surgery has adopted the following statement to clarify the standard of care applicable to the evaluation of an individual for the purpose of certification to use marihuana for any medical condition:

> Generally accepted components of a full medical evaluation to determine suitability and appropriateness for recommending treatment of any kind, including certification for medical marihuana, include:
>
> - a hands-on physician patient encounter
> - full assessment and recording of patient's medical history
> - relevant physical examination
> - review of prior records of relevant examinations, treatments and treatment response including substance abuse history
> - receipt and review of relevant diagnostic test results
> - discussion of advantages, disadvantages, alternatives, potential adverse effects and expected response to treatment
> - development of plan of care with state goals of therapy
> - monitoring of the response to treatment and possible adverse effects
> - creation and maintenance of patient records documenting the information above
> - communication with patient's primary care physician when applicable

The Boards expect that these medical encounters would be completed at permanent locations that enable the patient to return for follow-up, consultation or assistance as needed.

A physician failing to meet generally accepted standards of practice when certifying a patient to use marihuana for a medical condition may be found to be practicing below the acceptable standard of care and therefore may be subject to disciplinary action.

FEASIBILITY AND COST OF OUTSOURCING THE MEDICAL MARIHUANA PROGRAM

(FY2010 Appropriation Bill - Public Act 131 of 2009)

March 1, 2010

Section 727: By March 1 of the current fiscal year, the department shall report to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on the feasibility and cost of outsourcing the medical marihuana program. The report shall include the current projected annual cost of the program and the current projected annual fee revenue. If the report identifies privatization savings of 10% or greater and privatization is allowable under the Michigan medical marihuana act, 2008 IL 1, MCL 333.26421 to 333.26430, the department, in consultation with the department of management and budget, shall establish and implement a bid process to identify a private or public contractor to provide management of the medical marihuana program.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor
Janet Olszewski, Director

STATE OF MICHIGAN
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

REPORT TO THE LEGISLATURE

PA 131 OF 2009
SECTION 727.

FEASIBILITY AND COST OF OUTSOURCING THE MEDICAL MARIHUANA PROGRAM

March 1, 2010

I. Background

This report is submitted in response to boilerplate language in PA 131 of 2009, Sec. 727, which requires the Department of Community Health, by March 1 of the current fiscal year, to:

> *"report to the house and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director on the feasibility and cost of outsourcing the medical marihuana program. The report shall include the current projected annual cost of the program and the current projected annual fee revenue. If the report identifies privatization savings of 10% or greater and privatization is allowable under the Michigan medical marihuana act, 2008 IL 1, MCL 333.26421 to 333.26430, the department, in consultation with the department of management and budget, shall establish and implement a bid process to identify a private or public contractor to provide management of the medical marihuana program. "*

II. Feasibility of Outsourcing the Medical Marihuana Program

The Michigan Medical Marihuana Act requires the Department of Community Health to establish and administer the Medical Marihuana Program (MMP). In assessing the feasibility of outsourcing the program, the Department evaluated whether it could enter into a contract with a private or public contractor to provide management of the MMP and specifically whether a private, non-governmental entity could process the applications for registry identification cards for qualifying patients and primary caregivers under the Michigan Medical Marihuana Act (MMA).[1] Although the Act does not expressly authorize the Department to outsource this work, the Department under the Public Health Code[2] may contract with a private vendor to process the applications.

Subsection (6)(c) of the MMA[3] requires the Department to approve or deny applications for registry identification cards for qualifying patients and primary caregivers:

> The department shall verify the information contained in an application or renewal submitted pursuant to this section, and shall approve or deny an application or renewal within 15 days of receiving it . . . .

Similarly, subsection (6)(d) of the MMA[4] requires the Department to issue registry identification cards within 5 days of approving an application:

> The department shall issue registry identification cards within 5 days of approving an application or renewal, which shall expire 1 year after the date of issuance. . . .

---

[1] MCL 333.26421 *et seq.*
[2] MCL 333.1101 *et seq.*
[3] MCL 333.26426(6)(c).
[4] MCL 333.26426(6)(d).

Neither one of these subsections expressly authorize anyone other than the Department to carry out these legal duties.

Even though the MMA does not expressly authorize anyone other than the Department to process the applications for registry identification cards, section 2226 of the PHC[5] authorizes the Department to execute agreements with persons to assist the Department in carrying out its duties:

> The department may:
>
> * * *
>
> (c) Enter into an agreement, contract, or arrangement with governmental entities or other persons necessary or appropriate to assist the department in carrying out its duties and functions.

Section 2226 of the PHC authorizes the Department to contract with a private entity to "assist the Department in carrying out its duties and functions." Processing those applications is one of the Department's "duties and functions," and the Department may enter into an agreement with "governmental entities or other persons" to carry out those duties. If the Department were to find that it is "necessary or appropriate" to contract with a private entity to process the applications, then section 2226 of the PHC would authorize the Department to contract with a private entity.

The MMA requires the Department to perform the administrative duty of processing applications. It is the Department's opinion that making the final determinations on whether an application is approved or denied should remain with the Department; it would be an improper delegation of the Department's authority for a contractor to make the actual decision to grant or deny the application. There should not be an issue contracting with a private entity to review applications for background, form and content and making a recommendation to the Department. This could be satisfied by having a process where the Department reviews/approves the recommendations from the private contractor based on its application review. The contractor could perform functions to assist the Department in performing its duties and functions, but not completely assume those duties and functions. This would result in a more complicated process, reduce opportunities for efficiency, and require both the Department and the contractor to hire staff to handle their respective responsibilities. Under MCL 333.26426(c), the Department must approve or deny an application within 15 days. Having the Department retain final decision-making authority, there may be practical difficulties in completing the entire approval process within 15 days.

Even though the Department may delegate its duty to process applications and make recommendations for approval to a private contractor, the Department also has confidentiality obligations under the MMA.[6] If the Department were to contract with a private contractor, then the Department would have to require the contractor to comply with those confidentiality obligations. The Department currently links its system with the state police's Law Enforcement Information Network (LEIN), and it is not clear whether a private contractor would have access

---

[6] See MCL 333.26426(h).

to LEIN. Subsection (6)(h) of the MMA[7], however, only requires the Department to verify with law enforcement whether a registry identification card is valid. If the Department were to contract for the processing of the applications, it might require the contractor to provide the Department with a current list of valid registry identification cards. If the State Police would not or could not provide access to LEIN to a private contractor, then the Department might rely upon the information from the contractor to then directly report that information to the State Police upon request, and therefore fulfill its obligation. This assumes that under the terms of the contract with the private entity the Department no longer maintains the MMP registration database.

II. Cost of the Medical Marihuana Program

A. Program Statistics

As of February 22, 2010, the Michigan Medical Marihuana Registry has received 17,355 applications with 12,917 cards issued to 9,105 patients and 3,812 caregivers; there are currently 6,339 registrations pending due to lack of staff. Initially the Bureau of Health Professions received an average of 50 applications per day. By January 2010 the average number of applications received daily increased to 80 and February 2010 has seen an increase to 162 applications per day.

B. Medical Marihuana Program Fees

MCL 333.26425 gives the Department the authority to establish application and renewal fees that generate revenues sufficient to offset all expenses of implementing and administering the MMA through the promulgation of Administrative Rules. The Department reviewed the application and renewal fees established by those states with existing Medical Marihuana programs and established fees based on the average fees charged by other jurisdictions. Currently, the fee for a new or renewal application is $100.00, unless a qualifying patient can demonstrate his or her current eligibility in the Medicaid program or receipt of current SSD or SSI benefits, in which case the application fee is $25.00. Approximately 60% of the applicants qualify for the reduced fee.

C. First Year Anticipated Costs and Revenues

Revenue	
Actual revenue from April 2009 – January 2010	$1,025.981
Estimated annual revenue – Year 1	$1,231,177
Program Costs	
Estimated annual expenses	$ 717,179
Estimated Balance in Fund	$ 513,997

[7] MCL 333.26426(h)(3).

D. Second Year Anticipated Costs and Revenue

Revenue

Estimated annual revenue – Year 2 $1,100,385 to $2,024,165*

** Based on estimates of 81 applications/renewals per day to 149 applications/renewals per day.*

Program Costs

Estimated annual expenses – Year 2 $1,163,687*

** The department has determined that additional staff and resources will be necessary to comply with the required timeframes. Initial estimates are that a minimum of five additional full time staff will be necessary. Assumes 98% of the individuals who received a permit in Year 1 will reapply in year 2. It should be noted that the renewal process requires the same process as an initial application so resource demand is the same.*

III. Estimating Program Volume

One of the difficulties encountered in estimating revenue and expenses associated with the program, as well as estimating the cost of outsourcing, is the inability of the Department to accurately estimate the number of applications it will receive on an annual basis. Although the Department expects the volume of new applications to eventually taper off, there is no way to know when the Department might begin to see a significant decrease in the number of new applications. In addition to new applications, the Department estimates that approximately 96-98% of individuals holding a registration card will renew each year. For example, the Department estimates that in Year 2, approximately 14,000 renewal applications will be processed. In addition, the Department will continue to receive new applications on a daily basis. The Department assumes it will continue to receive an average of 80-100 applications daily for most of Year 2. It would be reasonable to assume that the Department could double the current number of permit holders by the end of Year 2, resulting in a total of 26,000-28,000 permit holders. This means that for Year 3, the Department would be renewing approximately 24,000-26,000 permits as well as approving new applications throughout the year.

IV. Cost of Privatizing the Medical Marihuana Program

The Department has requested informal information from two vendors regarding the possible cost of processing data-entry and creation of cards for the program.

- The National Medical Marijuana Foundation which is located in Sarasota, Florida has offered a pricing proposal based on a per unit cost. If the Department continues to receive the number of new applications it receives per month, for the next year, the cost for processing new patients or caregivers would total $709,800. The Department also needs to process renewals for an anticipated 20,000 current patients and caregivers which would result in an additional cost of $215,000. The total for these two functions would be $924,800. There would be an additional charge for changes to records.

The Department would continue to incur expenses associated with approving or denying the applications as described in Section II, Feasibility of Outsourcing the Medical Marihuana Program. The estimated cost for processing approvals or denials, including contract administration and management of Department staff, would total $451,049.

Based on the current information available to the Department, the estimated annual cost of outsourcing portions of the Medical Marihuana Program, including costs that would continue to be incurred by the Department, would be approximately $1,375,849.

- The second vendor, Greenlife docs.com of Los Angeles, California, submitted a proposal based on a range of costs. Based on the information submitted by the vendor, the cost for processing new patients or caregivers could range from $811,200 to $1,216,800. There would be an additional cost of $400,000 - $600,000 for processing renewals. There would also be an annual service charge of $60,000 - $120,000. The total cost for providing their services could range from $1,271,200 - $1,936,800.

  The estimated cost for this vendor, combined with the Department's ongoing costs, would be approximately $1,722,249 to $2,387, 849.

The estimated annual cost of outsourcing portions of the program to either vendor exceed the cost of retaining the program in the Department, based on an estimated cost to the Department of $1,163,687.

No Michigan vendors were identified as having current capabilities for this specialized program although some have expressed an interest in developing a system.

V. Conclusion

- The Department would be prohibited from establishing and implementing a bid process to identify a private or public contractor to perform all functions of the medical marihuana program. The Department could establish a bid process to identify an entity to perform data-entry and create and distribute registration cards. The Department would retain the final decision-making authority regarding the issuance of a registration to a patient or caregiver. After obtaining the Department's authorization to approve or deny the application, the contractor could issue the registration card or denial letter. Such a process would be cumbersome, difficult to complete within the timeframes provided in MCL 333.26426(c), and would result in additional inefficiencies.

- Clarification should be sought from the Office of the Attorney General as to whether the confidentiality provisions in MCL 333.26426(h) would prevent the Department from entering into a contract with a private or public contractor for the purpose of administering the medical marihuana program.

- The application and renewal fees established in the Administrative Rules are reasonable compared to other states with medical marihuana programs and are sufficient to support the cost of managing the program. Based on the information the Department did obtain, outsourcing the program would be costlier and the Department would not realize a privatization savings of 10% or greater.

STATE OF MICHIGAN

MIKE COX, ATTORNEY GENERAL

MEDICAL MARIHUANA ACT:
Department of Community Health

Authority of Michigan

to enter into an agreement

with a private or public contractor
DEPARTMENT OF COMMUNITY HEALTH:
administering the Medical Marihuana Program

for the purpose of

The Michigan Medical Marihuana Act, Initiated Law 1 of 2008, MCL 333.26421 *et seq,* does not prohibit the Department of Community Health from entering into an agreement or contract with an outside vendor to assist the department in processing applications, eligibility determinations, and the issuance of identification cards to patients and caregivers, if the Department of Community Health retains its authority to approve or deny issuance of registry identification cards.

2009 AACS, R 333.121(2) promulgated by the Department of Community Health under the Michigan Medical Marihuana Act, Initiated Law 1 of 2008, MCL 333.26421 *et seq*, which provides that the confidential information "may only be accessed or released to authorized employees of the department," prevents the Department of Community Health from entering into a contract with an outside vendor to process registry applications or renewals.

Opinion No. 7250

August 31, 2010

Honorable Roger Kahn, M.D.
State Senator
The Capitol
Lansing, MI 48909

You have asked two questions regarding the authority of the Michigan Department of Community Health (DCH) to contract out certain of its responsibilities under the Michigan Medical Marihuana Act (MMA or Act), Initiated Law 1 of 2008, MCL 333.26421 *et seq.*

The MMA was an initiative approved by a majority of Michigan voters in November 2008, and which became effective December 4, 2008. See Const 1963, art 2, § 9. Under the MMA, "[t]he medical use of marihuana is allowed under state law to the extent that it is carried out in accordance with the provisions of this act." MCL 333.26427(a). The Act protects qualifying patients with debilitating medical conditions, and their primary caregivers, if any, from arrest, prosecution, and penalty for the medicinal use of a limited amount of marihuana in accordance with the MMA. MCL 333.26424(d)(1) and (2). In order to receive the protections of the MMA, patients and caregivers must apply for and receive a registry identification card issued by DCH. MCL 333.26424(a).

You ask whether DCH is prohibited under the MMA from contracting with an outside vendor to handle the processing of applications, eligibility determinations, and the issuance of registry identification cards to patients and caregivers.

Because the Act was a citizen initiative under Const 1963, art 2, § 9, it must be interpreted in light of the rules governing the construction of citizen initiatives. "There is no essential difference in the construction of statutes enacted directly by the people

and those enacted by the Legislature." OAG, 1985-1986, No 6370, pp 310, 313-314 (June 10, 1986). "[A] study of all of the provisions of the initiated statute" may reveal the intent of the electorate. *Id.*

The key inquiry in construing an initiative is "the collective intent of the people," and the people's intent may be measured by their "common understanding . . . of the purpose of the initiated law." *Id.* The language of the ballot proposal itself and, when appropriate, the arguments set forth during the campaign regarding the initiative should be consulted in discerning the people's intent. *Id.*

The Michigan Court of Appeals has explained that initiatives should be "liberally construed to effectuate their purposes" and to "facilitate rather than hamper the exercise of reserved rights by the people." *Welch Foods v Attorney General,* 213 Mich App 459, 461; 540 NW2d 693 (1995). In addition, the words of an initiated law should be given their "ordinary and customary meaning as would have been understood by the voters." *Id.* To the extent that the initiative contains any ambiguity, it must be constructed in light of the purpose of the initiative. *Id.* at 462.

The MMA is silent with respect to whether DCH may contract with a third party to carry out its duties to process applications and issue registry identification cards. The Act defines the term "department" as used in the Act to mean "the state department of community health," or DCH. MCL 333.26423(b). Section 6(a) of the Act provides, in part, that "[t]he department shall issue registry identification cards to qualifying patients . . . ." MCL 333.26426(a). Section 6(c) states that "[t]he department shall verify the information contained in an application or renewal submitted pursuant to this section, and shall approve or deny an application or renewal within 15 days of receiving it." MCL 333.26426(c). Similarly, section 6(e) directs that "[t]he department shall issue registry identification cards within 5 days of approving an application or renewal, which shall expire 1 year after the date of issuance." MCL 333.26426(e). Nowhere in the language of these sections – or the other relevant provisions of the Act – does the MMA refer to or authorize an entity other than DCH to perform its statutory duties.

However, by specifically designating DCH as the state department charged with carrying out the duties of the MMA, the Act implicitly incorporated the administrative or ministerial powers and authority that enable the department to function as a department. Part 22 of the Public Health Code (Code), 1978 PA 368, MCL 333.2201 through 333.2264, describes the general powers and duties of the Department of Public Health, now DCH, and its director. MCL 333.2226(c) provides that "[t]he department may" "[e]nter into an agreement, contract, or arrangement with governmental entities or other persons necessary or appropriate to assist the department in carrying out its duties and functions." This section clearly authorizes DCH to engage the services of a third party to assist the department in performing its duties.[1] Pursuant to the MMA, the processing and issuance of medical marihuana registry identification cards are now duties or functions of DCH. Reading the Act and section 2226(c) of the Code in harmony with one another leads to the reasonable conclusion that DCH may exercise its authority to contract with a third party to assist the department in carrying out its new functions and duties under the MMA. See, e.g., *Edmond v Dep't of Corrections*, 254 Mich App 154, 157-158; 656 NW2d 842 (2002).

This interpretation is consistent with the principle that initiatives should be "liberally construed to effectuate their purposes" and to "facilitate rather than hamper the exercise of reserved rights by the people." *Welch Foods*, 213 Mich App at 461. Allowing DCH to utilize an outside vendor to process registry applications furthers the purpose of the Act by helping ensure the efficient processing of current and future applications and renewals.

There is a caveat, however. While DCH may enter into an agreement with an outside vendor to "assist" the Department in processing registry applications, DCH cannot delegate its discretionary authority to make a final determination with respect to the issuance of registry identification cards. In OAG, 1979-1980, No 5639, p 580 (January 31, 1980), the Attorney General concluded that the Barrier Free Design Board could not delegate its duties to grant or deny exceptions to the barrier free design requirements "because administrative agencies may not delegate the exercise of discretionary acts unless they have been granted legislative authority to do so." *Id.* at 581. The Barrier Free Design Board had not been granted such authority.

Similarly, the MMA only empowers DCH to grant or deny applications for registry identification cards. Thus, it would constitute an improper delegation of the department's authority if an outside vendor were charged with the ultimate task of granting or denying registry identification cards. Ultimately DCH – through its authorized employees – must make the final decision whether to grant or deny an identification card under the Act. DCH, however, may delegate "ministerial duties" such as receiving and processing patient applications to an outside vendor. *Id.*

It is my opinion, therefore, in answer to your first question, that the Michigan Medical Marihuana Act, Initiated Law 1 of 2008, MCL 333.26421 *et seq*, does not prohibit the Department of Community Health from entering into an agreement or contract with an outside vendor to assist the department in processing applications, eligibility determinations, and the issuance of identification cards to patients and caregivers, if the Department of Community Health retains its authority to approve or deny issuance of registry identification cards.

You next ask whether the confidentiality provisions in the MMA have the effect of preventing DCH from entering into a contract with an outside vendor for the purpose of assisting the department in administering the Medical Marihuana program.

The MMA's confidentiality provisions apply to a "person," including DCH and other state agencies and local units of government, as well as law enforcement agencies. Section 6(h) of the Act specifically describes the information deemed confidential or expressly exempted from public disclosure:

> (1) Applications and supporting information submitted by qualifying patients, including information regarding their primary caregivers and physicians,
> are confidential.
>
> (2) The department shall maintain a confidential list of the persons to whom the department has issued registry identification cards. Individual names
> and other identifying information on the list is confidential and is exempt from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231
> to 15.246.
>
> (3) The department shall verify to law enforcement personnel whether a registry identification card is valid, without disclosing more information than is
> reasonably necessary to verify the authenticity of the registry identification card.
>
> (4) A person, including an employee or official of the department or another state agency or local unit of government, who discloses confidential
> information in violation of this act is guilty of a misdemeanor, punishable by imprisonment for not more than 6 months, or a fine of not more than
> $1,000.00, or both. [MCL 333.26426(h).][2]

While names, other personal identifying information, applications and information regarding patients, primary caregivers or physicians are deemed confidential and must not be disclosed contrary to the Act, DCH is implicitly authorized to disclose this information to the extent necessary to fully perform its duties under the Act.[3] For example, in verifying the information contained in the application, DCH would need to disclose the name of the applicant to the physician listed on the application. Similarly, the MMA would not prohibit DCH from sharing the information with an outside vendor under contract with DCH to assist it in carrying out the application and registration process, so long as the contractual arrangement protected the confidentiality of the information. Under the MMA, any person who gains access to the confidential information would be required to protect its confidentiality under threat of criminal fines and incarceration: "A person . . . who discloses confidential information in violation of this act is guilty of a misdemeanor, punishable by imprisonment for not more than 6 months, or a fine of not more than $1,000.00, or both." MCL 333.26426(h)(4).

DCH has addressed the subject of confidentiality in duly promulgated administrative rules. Section 5(b) of the MMA provides that: "the department shall promulgate rules . . . that govern the manner in which it shall consider applications for and renewals of registry identification cards for qualifying patients and primary caregivers." MCL 333.26425(b). Acting under that authority, DCH promulgated the following rule to implement the requirement to keep information confidential:

> (1) Except as provided in subrules (2) and (3) of this rule, Michigan medical marihuana program information shall be confidential and not subject to
> disclosure in any form or manner. Program information includes, but is not limited to, all of the following:
>
> (a) Applications and supporting information submitted by qualifying patients.
>
> (b) Information related to a qualifying patient's primary caregiver.
>
> (c) Names and other identifying information of registry identification cardholders.
>
> (d) Names and other identifying information of pending applicants and their primary caregivers.
>
> (2) *Names and other identifying information made confidential* under subrule (1) of this rule *may only be accessed or released to authorized employees*
> *of the department as necessary to perform official duties of the department* pursuant to the act, including the production of any reports of non-identifying
> aggregate data or statistics.
>
> (3) The department shall verify upon a request by law enforcement personnel whether a registry identification card is valid, without disclosing more
> information than is reasonably necessary to verify the authenticity of the registry identification card.

(4) The department may release information to other persons only upon receipt of a properly executed release of information signed by all individuals with legal authority to waive confidentiality regarding that information, whether a registered qualifying patient, a qualifying patient's parent or legal guardian, or a qualifying patient's registered primary caregiver. The release of information shall specify what information the department is authorized to release and to whom. [2009 AACS, R 333.121; emphasis added.]

The plain terms of the rule only allow employees of DCH to have access to the confidential information as necessary to perform the department's duties under the MMA, which include the processing of applications, eligibility determinations and issuance of registry identification cards. An agency is legally bound by its own valid administrative rules. Detroit Base Coalition for Human Rights v Social Services Dep't, 431 Mich 172, 189; 428 NW 2d 335 (1988). Accordingly, the next question to be determined is whether R 333.121 is valid.

In *Luttrell v Dep't of Corrections*, 421 Mich 93, 100; 365 NW2d 74 (1984), the Court adopted the following test for determining the validity of agency rules, citing *Chesapeake & Ohio R Co v Public Service Comm*, 59 Mich App 88, 98-99; 228 NW2d 843 (1975):

"Where an agency is empowered to make rules, courts employ a three-fold test to determine the validity of the rules it promulgates: (1) whether the rule is within the matter covered by the enabling statute; (2) if so, whether it complies with the underlying legislative intent; and (3) if it meets the first two requirements, when [*sic*] it is neither arbitrary nor capricious."

An agency's construction of a statute "is entitled to respectful consideration and, if persuasive, should not be overruled without cogent reasons," but "the court's ultimate concern is a proper construction of the plain language of the statute." *In re Rovas Complaint*, 482 Mich 90, 108; 754 NW2d 259 (2008). "[T]he agency's interpretation cannot conflict with the plain meaning of the statute." *Id.*

The MMA provides strict confidentiality requirements, violations of which are criminal offenses. In an effort to ensure compliance with the requirement, subsection (2) of the Rule provides that confidential information may only be accessed or released to DCH *employees* for purposes of performing official duties under the MMA.[4] That rule would not allow DCH to contract with an outside vendor, giving the vendor's employees access to the confidential information. Although stricter than required by the MMA, the rule is a reasonable implementation of the confidentiality provisions of the MMA and in the absence of any provision providing for release of confidential information to third-party vendors, is not inconsistent with the intent of the voters. Accordingly, DCH may not contract with an outside vendor to process registry applications since it may not give the vendor access to the necessary information.[5]

To remedy this situation, DCH could promulgate a new rule as provided in MCL 24.241 and 24.242, or issue an emergency rule if appropriate under MCL 24.248, to allow DCH to pursue contracts with outside vendors permitting access to confidential information under terms that protect the confidentiality. Alternatively, the Legislature could act to amend or rescind the rule, MCL 24.231(5), 24.251, or specifically amend the MMA to allow DCH to pursue contracts with outside vendors. Const 1963, art 2, § 9.

It is my opinion, therefore, in answer to your second question, that 2009 AACS, R 333.121(2) promulgated by the Department of Community Health under the Michigan Medical Marihuana Act, Initiated Law 1 of 2008, MCL 333.26421 *et seq*, which provides that the confidential information "may only be accessed or released to authorized employees of the department," prevents the Department of Community Health from entering into a contract with an outside vendor to process registry applications or renewals.

MIKE COX
Attorney General

[1] Notably, this section does not restrict its application to duties or functions assigned by the Code, as other sections do. See MCL 333.2205(1), which states "[a] function assigned by this code to the department vests in the director or in an employee or agent of the department designated by the director, or in any employee or agent of the department who is assigned the function in accordance with internal administrative procedures of the department established by the director."

[2] The MMA does require DCH to make public, via an annual report to the Legislature, certain information:

(1) The number of applications filed for registry identification cards.

(2) The number of qualifying patients and primary caregivers approved in each county.

3) The nature of the debilitating medical conditions of the qualifying patients.

(4) The number of registry identification cards revoked.

(5) The number of physicians providing written certifications for qualifying patients. [MCL 333.26426(i).]

[3] The Supreme Court has ruled: "The absence of an explicit grant of authority is not dispositive. This Court, in *Coffman v State Bd of Examiners in Optometry*, 331 Mich 582, 590; 50 NW2d 322 (1951), said 'powers [of administrative boards] are limited by the statutes creating them to those conferred expressly *or by necessary or fair implication.*' Quoting 42 Am Jur, § 26, pp 316 ff (emphasis added)." *Public Health Dep't v Rivergate Manor*, 452 Mich 495, 503; 550 NW2d 515 (1996).

[4] DCH may also disclose confidential information to law enforcement personnel to verify whether an identification card is valid, "without disclosing more information than is reasonably necessary to verify the authenticity of the registry identification card." MCL 333.26426(h)(3).

[5] It is worth observing that R 333.121(4), which authorizes the release of confidential information to additional persons if a waiver is obtained, does not provide a mechanism for allowing DCH to contract with an outside vendor because nothing in the MMA suggests that the processing of an application can be contingent upon a patient's waiver of his or her right to confidentiality. There are also practical concerns with obtaining the necessary waivers from all of the appropriate individuals on a case-by-case basis.

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET January 19, 2012
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

NOTICE
TO
CONTRACT NO. 071B2200116
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR **IdentiSys Inc.** **7630 Commerce Way** **Eden Prairie, MN 55344** **Email:tim_smit@identisys.com**	TELEPHONE (616) 895-2047 **Tim Smit** CONTRACTOR NUMBER/MAIL CODE BUYER/CA (517) 373-6535 **William C. Walsh, CPPB**
Contract Compliance Inspector: Celesta Clarkson (517) 373-4992 Clarksonc@michigan.gov **Card Issuance System – Department of Licensing and Regulatory Affairs**	
CONTRACT PERIOD: 3 yrs. + 2 one-year options From: **January 17, 2012** To: **January 16, 2015**	
TERMS **Net 45**	SHIPMENT **As Directed**
F.O.B. **Destination/Installed**	SHIPPED FROM **Eden Prairie, MN**
ALTERNATE PAYMENT OPTIONS: ☐ P-card ☐ Direct Voucher (DV) ☐ Other	
MINIMUM DELIVERY REQUIREMENTS **N/A**	
MISCELLANEOUS INFORMATION: **N/A**	

The terms and conditions of this Contract are those of ITB 071I2200047, this Contract Agreement and the vendor's quote dated December 7, 2011. In the event of any conflicts between the specifications, and terms and conditions, indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Contract Value: **$829,726.84**

The Genesee County Compassion Club

Founded in March of 2009 as a non-profit corporation, the Genesee County Compassion Club is Michigan's largest Compassion Club with over 5500 members to date.

The G3C was formed to provide information to State Registered Patients and Caregivers in regard to current laws, patient rights and the medicinal applications of Cannabis. We also provide a safe, private environment for Patients and Caregivers to meet on neutral ground.

Currently, the G3C employs a staff of twelve, and is open five days a week, with an average of 250-300 members through our doors on a daily basis. To date we have had zero complaints from our neighbors and zero incidents or encounters requiring law enforcement. We believe that we have made a positive impact in our community by contributing over $20,000.00 to various charitable organizations including: Disabled Veterans Fund, V.A. Saginaw/Aide to Needy Vets Fund, Eastern Michigan Food Bank, Michigan Deputy Sheriff's Association, Children's Neuroblastoma Foundation and North End Soup Kitchen. Assistance was also given to seven local families that suffered tragedy such as house fires and loss of a loved one. This will also be the third year that G3C Members clean highway M13 with the Adopt-A-Highway program.

There was no existing zoning when we opened our Clubhouse doors, but we did seek permission from our local township prior to opening. One year later the township passed an ordinance - one in which we did not need to change or modify our operations to maintain compliance. We specifically chose to establish our club as a non-profit organization in order to do our best in complying with Federal Law. Additionally, we chose to operate our Clubhouse not only as an educational center, but as a safe access point for patients. An environment where patients can obtain information, find an appropriate caregiver and find medicinal cannabis facts. Our club does not provide any cannabis, but instead provides individual spaces that are rented to the Patient/Caregiver. The rent collected pays the overhead costs of operation and both Patient and Caregiver have a neutral environment in which to meet. Each member entering the Clubhouse must provide proof of valid enrolment with the State MMMP. Every member renting a space must provide proof of Patient/Caregiver relationship along with the cannabis they bring on the premises. The G3C Staff weigh and inspect all cannabis to ensure that no member has more than the acceptable limits contained within the MMMA of 2008.

The G3C welcomes all inquiries and offers private tours of the Clubhouse to any Official who may be interested in the day to day mechanics of our organization.

Genesee County Compassion Club
G-3094 N. Center Rd.
Flint, Mi. 48506
(810) 250-0054
www.genesee3c.com

Currently, there are more than 20 bills that have been introduced in the state legislature, which would amend or affect the Michigan Medical Marijuana Act (MMMA) of 2008. Many of these bills would undermine Michigan's citizen initiated law by preventing a patient's access to physician recommended medicine. Additionally, the bills would nullify the core protections set forth in the law by preventing municipalities from being sued for violating the MMMA, forbidding patients from cultivation in their own homes and making it illegal for patients and caregivers to even obtain a cannabis seed.

The Genesee County Compassion Club was founded in March of 2009 as a Michigan non-profit corporation. We offer legally registered patients and caregivers a neutral space to meet, education and assistance in navigating the MMMA (and all it contains), in addition to many enrichment endeavors throughout our community. While we respect the desire for additional clarification in regards to the existing law, it is our hope that together we can affect positive patient outcomes as well as bring clarity, responsibility and accountability to our industry. Included below are summary as well as impact analysis for 16 of the proposed bills.

HB4463- Prohibits anyone with a felony conviction from becoming a caregiver

Under the MMMA, persons with a felony drug conviction are already deemed ineligible to serve as a caregiver.

Position – Neutral. Current provisions are already in existence on the proposed issue.

HB4661 – Prohibits cultivation within 500 feet of a church, school or daycare center

This bill would prohibit patients and caregivers from cultivating within 500 feet of said facilities. Violators would have their medical marijuana registry card revoked.

Position – Neutral, many municipalities have enacted distance limits in regards to cultivation. However, this should not apply to patients cultivating at their own residence.

HB4834 – Requires photograph on registry card; provides for sharing of identification information to law enforcement

One section of the bill requires applicants to submit a 2"x2" passport style photograph taken within the preceding 6 months. Separately, the bill allows for Department of Licensing and Regulatory Affairs to disclose information to law enforcement if provided with the individual's name and date of birth or registry ID number.

Position – Neutral, the addition of current photographs will further protect patients and discourage false cards/documents. Law enforcement should be able to assess the validity of any

registry card presented, providing they have probable cause to believe the individual is acting outside of the MMMA.

HB4850 – Prohibits patient-to-patient transfers

This bill would prohibit patient-to-patient transfers by making the law's affirmative defense unavailable to individuals who transfer cannabis to anyone if the transferor is not the primary caregiver and the transferee is not a patient connected through the registry program. Additionally, patients (and other cardholders) could not obtain cannabis from anyone other than their caregiver.

Position – Strongly opposed on many levels. This bill could nullify the MMMA by prohibiting patients and caregivers from obtaining seeds, which are an undeniable necessity for cultivation. One of the most efficient and affordable ways for patients to acquire medicinal cannabis is from other patients who produce their own and have overages they can transfer. It takes months for a planted cannabis seed to grow in to a plant that is capable of producing medicine and this bill would force unnecessary suffering upon many terminal and chronic patients who require cannabis immediately.

HB4851 – Defines a "bona fide physician/patient relationship"

This bill would require patients to receive their recommendation from a physician with whom s/he has had a long standing relationship. In addition, the physician must complete a full assessment of the patients history, treat the patient for a reason other than the recommendation, conduct an in person evaluation, have an expectation to provide follow up care, maintain full records and notify the patients primary physician, if appropriate.

Position – While at first reading this bill may seem innocuous, the discriminatory angle within it must be addressed. Given the limited number and accessibility of physicians who are knowledgeable and comfortable with medicinal cannabis, the burdens imposed by this bill, both financial and logistical, are too onerous for patients. Individuals have a hard enough time finding one primary physician in today's world, let alone a second physician with whom they must establish a long standing relationship. Numerous patients receive physician recommendations for alternative medicine every day (chiropractic, acupuncture, naturopathy, etc.) and in keeping with established industry protocol along with the spirit and intent of the law, it should be noted that MMMA approval is enacted as a recommendation, not a prescription.

HB4852 – Allow local zoning of marijuana cultivation

This measure would allow local communities, through zoning ordinances, to decide when, whether and where patients and caregivers could cultivate cannabis.

Position – The ability of patients and caregivers to cultivate medicinal cannabis is the largest of the core rights Michigan voters sought to protect in passing the MMMA. Communities should be free to regulate the time, place and manner of operating dispensaries; localities should not be able to forbid patients and individual caregivers from in home cultivation.

HB4853 – Makes it a class G felony to sell medical marijuana in violation of the registry identification card restrictions

This bill would make "selling marijuana in violation of registry identification card restrictions" a class G felony, punishable by up to 2 years in prison.

Position – Opposed. Firstly, selling cannabis outside the confines of the MMMA is already a crime. Second, it is extremely vague in that the circumstances and terms ("in violation of registry identification card restrictions") of the bills redundant violation are undefined.

HB4854 – Prohibits advertising of caregiver services or other offers to sell, transfer or make cannabis available.

This bill would make it a misdemeanor offense to advertise caregiver service, or other offers to "make available marijuana". It would allow the department to provide information to patients in regards to caregivers or other sources to obtain plants.

Position - The United States Supreme Court has determined that even commercial speech is granted certain constitutional protections. Free speech is a cornerstone of our democracy. While some restrictions and guidelines on advertising may be appropriate, an outright ban goes too far.

HB4856 – Provides certain limitation for the transportation of cannabis by vehicle

This bill prohibits the transportation of cannabis unless enclosed in a case, contained in the trunk or is otherwise inaccessible from the passenger compartment. Violation would be a misdemeanor subject to a fine of up to $100 or imprisonment up to 90 days.

Position – It is understandable that some transportation restrictions are of concern and so, we offer no opposition to the bill.

SB321 – Exempts medicinal cannabis from personal insurance coverage requirements

Not only would this bill mean that insurance providers are not required to compensate policy holders for medicinal cannabis, it would actually prohibit them from doing so.

Position – Opposed. Insurance carriers should not be required to cover medical cannabis, however, those who wish to should be free to do so.

SB377 – Makes patients' registry information available to state police upon issuance of card

If passed, this bill would require the Department of Licensing and Regulatory Affairs (LARA) to forward information concerning issuance of medical registry cards to the Department of State Police within 48hrs. This bill further deletes a requirement that any information disclosed be 'not more than reasonably necessary'.

Position – Strongly opposed. Law enforcement already has the ability to verify the validity of a patients' registry ID card through LARA. This bill radically undermines existing patient privacy protections and would subject patients to treatment akin to that of sex offenders or criminal suspects.

SB418 – Prohibits lawsuits against municipalities

This bill attempts to add a provision to the MMMA stating "nothing in this act shall be construed to create a private cause of action against this state or a political subdivision of this state". In essence, it bans patients, caregivers and advocates from suing municipalities and cuts off options to challenge impermissibly restrictive ordinances.

Position – Opposed. Currently there are municipalities that have enacted ordinances which are in direct conflict with the MMMA. Citizens should be free to challenge in court, any ordinance that plainly violates an enacted law.

SB504 – Prohibits transfers of cannabis within 1,000 feet of a school or church

In opposition to HB4661, this bill would not ban patient cultivation, but merely the transfer of cannabis within 1,000 feet of a clearly identified school or church. Additionally, the bill grants exception for transfers to registered patients within a residence.

Position – Neutral.

SB505 – Eligibility to register as a primary caregiver

As with the aforementioned HB4463, this bill prohibits anyone with a felony conviction from serving as a primary caregiver.

Position - Neutral, as with HB4463.

SB506 – Expands requirements to form "bona fide physician/patient relationship"

As with HB4851, this bill attempts to make obtaining a physician recommendation more difficult. In addition to the extensive list of requirements found in HB4851, SB506 includes that physicians must also provide information on alternative treatments, review prior treatment and create/maintain records. If the physician fails to do so, the patient would be ineligible to register and protections for doctors against civil or occupational sanctions would not apply.

Position – Along with opposition stated under HB4851, concerns arise when there is an attempt to force restrictions on medicinal cannabis recommendations when none exist for many far more dangerous prescribed narcotics.

SB17 and HB4397 – Prohibits the formation of Marijuana "clubs" or "bars"

Enacting this legislation would make it a misdemeanor, punishable by a fine of up to $500 and imprisonment of up to 90 days for operating a cannabis "club" or "bar", which is defined as a location where one or more people are allowed to use cannabis in exchange for the payment of a fee. This definition does not include nursing homes, hospices or any place where cannabis is legally dispensed.

Position – Concern lies in the wording of this bill. No opposition is offered in regards to cannabis consumption for a fee or within a traditional "bar" setting, however the inclusion of the word "clubs" could be misconstrued and wrongfully subject legally functioning non-profit organizations and established Compassion Clubs to unfounded discrimination. It should be noted that Health and Welfare Canada, along with other districts and municipalities have made formal distinction between "dispensaries" and "compassion clubs" within their laws.

David S. Leyton, Prosecuting Attorney
Genesee County Prosecutor'
100 Courthouse
900 S. Saginaw Street
Flint, MI 48502

The Genesee County Compassion Club is committed to providing Michigan Medical Marihuana Patients and Caregivers with the most relevant and up-to-date information for the safety and compliance of its members.

Upon initiation of the Law and the implementation of it within our organization, it became necessary to establish our own procedures for daily operations. We feel this is an important part of setting an example in the industry and that self-regulation is necessary in order to maintain a responsible presence in the community.

One of the compliance concerns we had to address prior to opening our doors in August 2009 was how to properly identify and validate participants in the Michigan's Medical Marihuana Program. Validation of ID Cards, either Patient or Caregiver, originally issued by the Michigan Department of Community Health, now (LARA) Michigan Department of Licensing and Regulatory Affairs along with a current photo identification was obviously the first requirement.

According to the LARA website, the State imposed a time limit of twenty (20) days for the issuing of these cards to each participant. That being five (5) days for regular mailing of the application and required documentation to the respective State department, and an additional ten (10) days for processing, followed by five (5) days for return mailing from the department, with either a State issued Medical Marihuana card or a denial letter. By Law, the applicants are deemed registered in the program after twenty-one (21) days, if the department has not responded within the allotted time.

Considering this portion of the Law and with the delays at the State level in processing, it was necessary for us to establish a procedure for validating this paperwork/application from the State. Using normal practices repeated in other industries, such as insurance and finance, which rely on the ability of validation to confirm eligibility in a program, the Genesee County Compassion Club was able to develop simple procedural guidelines for verification. That being the following:

- Valid State of Michigan Drivers License, or State ID Card
- Valid Genesee County Compassion Club Membership Card
- Valid MMMP Registry Card

In leiu of

- Copies of MMMP Application, completed and signed
- Proof of submission to LARA as evidenced by Certified Mailing, or cashed check or money order. (All dated twenty-one days prior to current date)

After two years of using this process, we have been successful in determining eligibility in the program while maintaining adherence to Michigan State Law. Upon review in Genesee County

and around the State, we have found that both individuals and other patient and caregiver access points are using the same method of validation.

We are providing the attached packet and would like to ascertain a professional opinion on this process from someone with your expertise. We understand the ideal situation is always have a current State issued card, however, with the continued delays in processing it is absolute that a patient and or caregiver will have to use their paperwork to validate their registration. We hope you would be able to give us some insight if there is anything we should add or take away from the process.

With this in mind, if you could be so kind and pass the packet along to the Sheriff's Department, and other local police agencies for their input, we hope that we might be able to establish this as the Official Process for Registered Cardholders, Access Centers, and Law Enforcement. It is our understanding that working through the process of validating State paperwork was not included in the Attorney General's Clearing the Air: Seminar. We hope that by addressing this small issue concerning the Michigan Medical Marihuana Law, we can establish a responsible working relationship with our community and law enforcement and start to clear up some of the supposed ambiguities in the law.

We wish to thank you for your time and consideration in this matter.

Respectfully submitted,

12/01/2011

Standard Procedures for Validating MMMP paperwork

1. Government issued, picture ID should be presented with a valid, State issued MMMP patient or caregiver card or copies of the following documents.
2. Patient application page that is properly completed, signed and dated. If patient has elected a caregiver then it must be properly filled out and possession of plants indicated.
3. Physician recommendation page that is properly completed, signed and dated. Application should be mailed within 90 days of the Physician's dated recommendation.
4. Proof of submission of paperwork to L.A.R.A. Acceptable proof being USPS return receipt mailing or a copy of the cashed check or money order that accompanied the paperwork and shows date of clearing.
5. In order for the above documents to be vaild, applicant must wait 21 calendar days from the date of receipt/check clearing, by L.A.R.A. Paperwork and documents dated 6 months (or longer) are subject to further verification such as correspondence from L.A.R.A. in regards to the delay in processing, etc.